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Cross-mentorship

A Unique Lens Into the Realities and Challenges of Diversity in Surgery

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Mentorship in surgery is a perennial topic of interest, as successful mentoring relationships are associated with improved career satisfaction, academic promotion, research productivity, and overall well-being.[1] While it is true that certain minority groups in surgery find great personal and professional benefit in receiving and providing mentorship among ''their own'' (ie, a female academic surgeon mentoring a female resident), it is important to recognize that many mentoring relationships, whether intentionally or otherwise, extend across gender, sexuality, generations, race, ethnicity, and other differences.[2] Lived examples of these include an Asian man hailing from the Northeast with no children mentoring a White mother of 2 from the South, or a White gay man being mentored by a Black heterosexual faculty member. As surgery fortunately becomes a more diverse specialty, such mentorship relationships occur all around and among us; however, they have neither been named nor explicitly studied in our field.

For this reason, The Association of Women Surgeons HeForShe Committee took interest in this rarely mentioned and vaguely defined concept of ''cross-mentoring'' with the intention of conducting focus groups to further explore the topic. However, as we began to pilot our survey questions with general surgery residents across the country, we were grossly unprepared for the eye-opening conversation that followed. We describe how, despite our collective expertise and devotion to diversity, equity, and inclusion, we were not immune to the effects of implicit bias. We hope that by sharing our reflections and highlighting the difficulties surrounding the study of mentorship, we may all learn important lessons.

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PILOT GROUP EXPERIENCE

We performed a pilot study of the originally drafted questions at 3 academic centers to elicit resident opinion. Two faculty members and 1 general surgical resident moderated the face-to-face socially distanced discussions involving 14 resident volunteers. The moderators made notes in real time documenting the details of the discussion to enable discussion and synthesis of qualitative results between the 3 moderators after the sessions were complete. A formal grounded theory approach was not utilized, as this was a pilot study.

When we introduced the notion of cross-mentoring, or mentoring across differences for people who are not alike in some way, residents struggled with the terminology, querying why every mentoring relationship is therefore not termed cross-mentoring, since all individuals are inherently different. Specifically, some residents felt that labeling cross-mentorship as such really ''aged'' the field and exposed a large generational gap. Our pilot groups believed that cross-mentoring is the new norm of surgical mentorship, as most mentor–mentee relationships in the modern era do and must, admittedly perhaps without a second thought, exist across a difference. Many residents stated that they seek out mentors based on necessity due to professional or personal aspects, not specifically for any demographic disparity, and that any unlikeness between them tends to be coincidental.

Perhaps the most interesting issue raised during our pilot by residents in response to a question regarding successful and failed cross-mentoring relationships was this: had we implied an inherent benefit to cross-mentoring, and if so, in whose favor did this tend to be? We based our questions on a prior qualitative study that evaluated aspects of successful and failed mentoring relationships in academic medicine.[3] For instance, 1 resident commented: ''*You need a question that asks* ''*what do you think a benefit of a cross mentoring relationship might be?*'' *because the questions assume that all would find a benefit, which some might not. Also, it seems that mentee would always be the underrepresented one in this schema—how do they benefit by being mentored by someone in a more privileged scenario? Or is it really just a way for mentor to widen their own perspective when they mentor someone underrepresented, without significant advantage to the mentee?*''

When our group debriefed the pilot results, this prompted significant self-reflection on both our research methodology and a broad variety of ethical topics. We ourselves had suffered from anchoring bias and researching in a silo—not only labeling and studying a phenomenon that we felt we understood but also assuming that others would understand and agree with our preconceptions and their importance.

REFLECTIONS

The more we talked, the more humbled we became. Our pilot group participants had so quickly stimulated such a rich conversation that we truly had not anticipated, and they also potentially unearthed our own implicit biases. By asking about successful and failed cross-

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mentoring relationships, we implied that cross-mentoring *should* be successful and *must not* be failed and placed the burden of upholding a successful cross-mentoring relationship on the participants, neglecting to acknowledge the role of numerous systemic barriers. Were we implying an inherent benefit to a White surgeon mentoring a resident from an under-represented minority (URM), playing into the concept of the ‘‘White Savior?’’ Were we perpetuating the ‘‘minority tax,’’ expecting URM residents to speak up and share their own (potentially negative) experiences about unsuccessful mentoring in focus groups, and serve as a lesson in cross-mentoring for their somehow dissimilar mentor?

A recent study of Black medical students found that a perceived lack of mentorship was considered a barrier to pursuit of a career in academic surgery, and the authors suggested formal mentorship as a possible solution.[4] Another study of URM residents found that Black and Hispanic/Latino residents actively sought out but had difficulty finding concordant mentors.[2] A national survey of orthopedic surgery residents found that those in minority groups were more likely to have fewer mentors and be less satisfied with their mentorship in residency.[5] One driving factor behind these unfortunate realities is the fact that in medicine altogether, including in surgery, we persistently lag behind in achieving diversity reflective of the general population.[6] Perhaps by ensuring rewarding mentorship to URM physicians we may collectively improve their recruitment and retention in the field. But until we have more URM physicians, is studying and improving cross-mentorship the solution?

Another theme that developed during our conversation was taking care not to synonymize cross-mentorship with the exclusive mentorship of traditionally defined URMs. The current definition of URM does not account for many Asian subgroups (ie, Chinese, Korean, and Indian), who are not under-represented in medicine compared with their respective census data but still comprise a minority population in medicine.[7] The anti-Asian racism associated with the COVID-19 pandemic has reminded us that these groups are at significant risk of marginalization. Aside from race and ethnicity, gender, and sexual orientation as factors in mentorship also remain grossly under-studied in medicine and surgery. How, then, do we ensure that all stakeholders have a seat at this stable?

CHALLENGES AHEAD

Consciousness of the need for diversity is a given. But what is truly needed is to turn the lens onto ourselves, performing a critical evaluation of the exclusionary practices of medicine and surgery. Just 12% of current medical school graduates come from a background traditionally considered to be a URM despite comprising 33% of the US population.[6] Proportions of URM applicants and matriculants to both surgical and nonsurgical specialties have not significantly changed in the last decade.[6] We have found that minority residents feel uncomfortable in their surgical programs, and minority faculty have little support specific to their needs.[8,9] A dearth of leaders and mentors who are, for example, women, LGBTQIA, and Hispanic is but one of many reasons for the progressive drop-out of such individuals, specifically in academic medicine.[10] We must investigate and educate ourselves on how diversity and the politics surrounding it play into the practice of surgery altogether, not just in mentorship. We should take care to study this topic of cross-mentorship without being too broad, too specific, or speaking for those who are not currently at our table.

When choosing their mentors, we know that individuals often use a ‘‘mosaic’’ approach, since each mentor may serve a purpose and possess a specific quality to which the mentee can relate. Naturally, this means that what is similar in 1 mentor–mentee dyad may be completely different in another. Each mentor and mentee brings a unique identity and lived story to the relationship. It is therefore inevitable, whether explicitly sought out or not (as our focus group residents pointed out) that individuals in a mentoring relationship will have profound differences in their characteristics. What we must not do is assume that every such relationship has been beneficial to those involved (or fraught with discrimination), but rather promote self-reflection to identify and address our own intrinsic and extrinsic biases to enable a psychologically safe environment for mentees. With this in mind, we propose 2 lines of action, which are not mutually exclusive: 1) continue to actively promote a wealth of diversity in surgery, using as broad a definition of diversity as possible, so that at all levels *any* person may access a mentor whom they feel can more easily understand and advise them, 2) acknowledge that differences among us will always exist and accordingly renew our enthusiasm for understanding, respecting, and embracing them, and 3) dedicate ourselves to consciously researching the cross-mentoring phenomenon so that we may be able to develop best practice guidelines for this critically understudied topic.

CONCLUSION

We were surprised when an exploratory focus group to check verbiage of survey questions incited such a provoking conversation, revealing how much more we have to learn and how far we have yet to travel. In the modern era of surgery, we must recognize that cross-mentoring *is* the new schema. Profound differences between us are the norm, not the exception, and we hope that sharing our realizations contributes to fostering growth, representation, and fulfillment for all.

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